FILE COPY

IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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June 23, 2010

Tom Whittemore
Communicare, Inc #4 Leland
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #4 Leland, provider #13G012

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #4 Leland, which was conducted on June 21, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 5, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 5, 2010. If a request for informal dispute resolution is received after July 5, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

BARBARA DERN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

BD/srp
Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G012 | A. BUILDING _____ B. WING _____ | 06/21/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNICARE, INC #4 LELAND | 4150 LELAND WAY BOISE, ID 83709 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 000 | INITIAL COMMENTS<br><br>The following deficiency was cited during the annual recertification survey.<br><br>The survey was conducted by:<br>Barbara Dern, QMRP, Team Leader<br>Jim Troutfetter, QMRP<br><br>Common abbreviations/symbols used in this report are:<br>IPP - Individual Program Plan<br>LPN - Licensed Practical Nurse<br>AQMRP - Assistant Qualified Mental Retardation Professional | W 000 | RECEIVED<br>JUL 09 2010<br>FACILITY STANDARDS | |
| W 356 | 483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT<br><br>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure comprehensive dental services were provided for 1 of 4 individuals (Individual #3) whose medical records were reviewed. This resulted in an individual's dental needs to not be met. The findings include:<br><br>1. Individual #1's IPP, dated 2/11/10, documented a 50 year old male diagnosed with moderate mental retardation.<br><br>His medical record contained a dental report, dated 12/22/09, which documented Individual #3 | W 356 | W356<br><br>Corrective Actions: In reviewing this situation, the RN Supervisor stated that she was aware of the report cited in the survey but that it had been prepared by a dental hygienist, not the dentist, and that she had not viewed this as an order needing follow up. The follow-up plan, as she understood it, was to see the dentist again in 6 months for a review of this situation. This has now happened.<br><br>We have a system in place whereby the RN supervisor reviews all medical records and nursing summaries on a monthly basis with each CCI location's LPN and this process will continue. The statement reported that "Individual #3 did not have a follow up visit to receive a crown" is correct but he did have a six month follow up visit scheduled to reassess his status with | 07/07/10 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7-7-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|---|
| | 13G012 | A. BUILDING _____ B. WING _____ | 06/21/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNICARE, INC #4 LELAND | 4150 LELAND WAY BOISE, ID 83709 |

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|---|---|---|---|---|
| W 356 | Continued From page 1<br>had one tooth that would "greatly benefit with crowns [sic]." There was no evidence of a follow-up visit to receive a crown.<br><br>When asked, the LPN, AQMRP, and Lead Worker, all stated during an interview on 6/17/10 from 3:30 - 4:40 p.m., Individual #3 did not have a follow up visit to receive a crown.<br><br>The facility failed to ensure Individual #3 received appropriate dental services as recommended. | W 356 | the dentist. Please see the attached letter from the dentist for further clarification.<br><br>Identifying Others Potentially Affected: Other individual's living at this location have their medical records reviewed routinely by the RN Supervisor whose assessment is that this review is thorough and that similar issues are not present.<br><br>System Changes: We are not planning to make any systems changes.<br><br>Monitoring: As stated previously, the RN supervisor reviews all medical records and nursing summaries on a monthly basis with each CCI location's LPN and this process will continue. | |

Bureau of Facility Standards

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| MM785 | 16.03.11.270.04(b)(i) Provision for Dental Treatment<br><br>Provision for dental treatment; and<br>This Rule is not met as evidenced by:<br>Refer to W356. | MM785 | MM785<br><br>Please refer to W356 | |

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JUL 09 2010
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Administrator TITLE 7-7-2010 (X6) DATE